

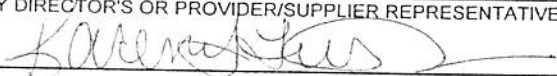
DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/07/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  445242	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  C 03/07/2012
---	---	--	--

NAME OF PROVIDER OR SUPPLIER  GREYSTONE HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 181 DUNLAP ROAD, PO BOX 1133 BLOUNTVILLE, TN 37617
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 203 SS=D	<p>483.12(a)(4)-(6) NOTICE REQUIREMENTS BEFORE TRANSFER/DISCHARGE</p> <p>Before a facility transfers or discharges a resident, the facility must notify the resident and, if known, a family member or legal representative of the resident of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand; record the reasons in the resident's clinical record; and include in the notice the items described in paragraph (a)(6) of this section.</p> <p>Except when specified in paragraph (a)(5)(ii) of this section, the notice of transfer or discharge required under paragraph (a)(4) of this section must be made by the facility at least 30 days before the resident is transferred or discharged.</p> <p>Notice may be made as soon as practicable before transfer or discharge when the health of individuals in the facility would be endangered under (a)(2)(iv) of this section; the resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (a)(2)(i) of this section; an immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (a)(2)(ii) of this section; or a resident has not resided in the facility for 30 days.</p> <p>The written notice specified in paragraph (a)(4) of this section must include the reason for transfer or discharge; the effective date of transfer or discharge; the location to which the resident is transferred or discharged; a statement that the resident has the right to appeal the action to the State; the name, address and telephone number of the State long term care ombudsman; for</p>	F 203	<p>Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truths or facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and /or executed solely because the provisions of Federal and State law require it.</p>	
		F 203	<p>What corrective action(s) will be done for residents found to have been effected by the deficient practice(s).</p> <p>Resident #4 was discharged from the facility on 2/15/2012.</p> <p>The facility has implemented a plan to provide hold bed and discharge notices to residents/families and/ responsible parties.</p>	3/22/2012

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE administrator	(X6) DATE 3/19/2012
--	------------------------	------------------------

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that her safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

MAR 23 2012

STATEMENT OF DEFICIENCIES PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>445242</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>03/07/2012</b>
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

REYSTONE HEALTH CARE CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE

181 DUNLAP ROAD, PO BOX 1133

BLOUNTVILLE, TN 37617

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------------	--	---------------------	--	----------------------------

F 203 Continued From page 1

nursing facility residents with developmental disabilities, the mailing address and telephone number of the agency responsible for the protection and advocacy of developmentally disabled individuals established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act; and for nursing facility residents who are mentally ill, the mailing address and telephone number of the agency responsible for the protection and advocacy of mentally ill individuals established under the Protection and Advocacy for Mentally Ill Individuals Act.

This REQUIREMENT is not met as evidenced by:

Based on medical record review, observation and interview, the facility failed to issue a thirty-day notice of discharge for one (#4) of seven residents reviewed.

The findings included:

Resident #4 was admitted to the facility on July 22, 2011, with diagnoses including End-Stage Liver Disease secondary to Hepatitis C, Encephalopathy, Chronic Pain, Bipolar Disorder, Osteoarthritis, Anxiety, Depression, Fibromyalgia, Anasarca (severe generalized edema) secondary to Cirrhosis, Anemia, Thrombocytopenia and Portal Hypertension.

Medical record review of the Minimum Data Set (MDS) dated November 28, 2011, revealed the resident had short and long-term memory problems and severely impaired decision-making skills; required extensive assistance with activities of daily living (ADL); and had bowel and bladder

F 203

**How facility will identify other residents having potential to be affected by practice AND what corrective action will be taken.**

Re-education was provided to admission and marketing staff on 3/7/2012 by administrator regarding providing to residents, families or responsible parties hold bed and discharge policy by phone and in writing. Education also included maintaining proof that resident, families or responsible parties received notification. Notification of discharges will be copied to the TN Dept of Health, Ombudsman and APS and other agencies as required by law.

MAR 23 2012

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/07/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>445242</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>03/07/2012</b>
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

REYSTONE HEALTH CARE CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE  
181 DUNLAP ROAD, PO BOX 1133  
BLOUNTVILLE, TN 37617

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------------	--	---------------------	--	----------------------------

F 203 Continued From page 2  
incontinence.

Observation on February 15, 2012, at 3:00 p.m., revealed the resident lying in a low bed with a fall mat. Observation revealed the resident had severe Ascites (accumulation of serous fluid in the peritoneal cavity) and a large umbilical hernia. Observation revealed the resident was alert but the speech was garbled.

Telephone interview on February 17, 2012, at 12:25 p.m., with the mother of resident #4 revealed the resident had been admitted to the hospital the previous evening on February 16, 2012.

Telephone interview on March 5, 2012, at 2:45 p.m., with the mother of resident #4 revealed the facility refused to readmit the resident after the hospital stay and revealed the facility had not issued a thirty-day notice of discharge.

Telephone interview on March 5, 2012, at 4:05 p.m., with the Administrator confirmed the facility would not accept the resident back after the hospital stay because "The mother made it clear we weren't meeting (resident #4's) needs." Continued interview with the Administrator confirmed a thirty-day notice of discharge had not been given to the resident.

C/O #28875

F 312 483.25(a)(3) ADL CARE PROVIDED FOR  
SS=D DEPENDENT RESIDENTS

A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal

F 203

**What measures will be put in place or what systemic changes you will make to ensure that the deficient practice does not recur.**

**The facility will maintain the documentation of verbal and written notification of the hold bed and discharge policy.**

**The administrator will audit 100% of discharged residents for the presence of verbal and written notification weekly for 2 weeks, then monthly for 4 months.**

**How corrective action will be monitored to ensure the deficient practice will not recur.**

**i.e. what quality assurance program will be put in place.**

**Audit results will be reviewed in the QA Committee meeting with changes to the plan or monitoring as deemed by the QA Committee.**

F 312

MAR 23 2012

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/07/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>445242</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>03/07/2012</b>
---	--	--	--

NAME OF PROVIDER OR SUPPLIER  <b>GREYSTONE HEALTH CARE CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>181 DUNLAP ROAD, PO BOX 1133</b> <b>BLOUNTVILLE, TN 37617</b>
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 312	<p>Continued From page 3 and oral hygiene.</p> <p>This REQUIREMENT is not met as evidenced by: Based on medical record review, observation and interview the facility failed to ensure mouth care was provided for two residents(#1 and #6) with tube feeding and a Tracheostomy and failed to ensure incontinence care was provided for one resident (#7) of seven residents reviewed.</p> <p>The findings included:</p> <p>Resident #1 was admitted to the facility on September 1, 2011, with diagnoses including Acute and Chronic Respiratory Failure, Traumatic Brain Injury, Contractures, Paralytic Ileus, Dysphagia, Anxiety, PEG (Percutaneous Endoscopic Gastrostomy) tube, Epilepsy, Hepatitis C, Tracheostomy with Ventilator Dependency and Gastrointestinal Reflux Disease.</p> <p>Medical record review of the Minimum Data Set (MDS) dated November 24, 2011, revealed the resident scored 11 of 15 on the Brief Interview for Mental Status (BIMS) with moderate impairment of cognitive skills; was totally dependent on staff for all activities of daily living (ADL); had an indwelling urinary catheter; and was fed by tube feeding.</p> <p>Observation and interview on February 15, 2012, at 10:00 a.m., in the resident's room revealed the resident in bed with a Tracheostomy and ventilator. Continued observation revealed the resident could not speak but could mouth words</p>	F 312	<p><b>What corrective action(s) will be done for residents found to have been effected by the deficient practice(s).</b></p> <p><b>Resident #1 and #6 received oral care on 2/15/2012.</b></p> <p><b>Resident #7 received incontinent care on 2/15/2012.</b></p> <p><b>CNA* #1 received education on oral care by the unit manager on 2/15/2012.</b></p> <p><b>How facility will identify other residents having potential to be affected by practice AND what corrective action will be taken.</b></p> <p><b>On 2/15/2012 residents were checked by the unit mangers to assure oral and incontinent care had been provided.</b></p> <p><b>Education was provided to nursing staff on 2/16/2012 by staff development coordinator regarding providing oral and incontinent care to residents.</b></p>	3/12/2012

MAR 23 2012



DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/07/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>445242</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>03/07/2012</b>
---	--	--	--

NAME OF PROVIDER OR SUPPLIER  <b>GREYSTONE HEALTH CARE CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>181 DUNLAP ROAD, PO BOX 1133 BLOUNTVILLE, TN 37617</b>
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 312	<p>Continued From page 4</p> <p>and move the head to answer questions. Continued observation revealed the resident's teeth and lips were coated with dried secretions. Interview with the resident confirmed mouth care had not yet been provided as the resident mouthed "no" and shook the head side to side.</p> <p>Observation and interview on February 15, 2012, at 10:05 a.m., in the resident's room, with Licensed Practical Nurse (LPN) #1 who was assigned to the resident confirmed the resident was in need of mouth care and "probably needs mouth care every hour."</p> <p>Interview on February 15, 2012, at 10:20 a.m., in the hallway, with Certified Nursing Assistant (CNA) #1 who was assigned to the resident revealed CNA #1 had been on duty four hours and twenty minutes (since 6:00 a.m.). Continued interview with CNA #1 confirmed mouth care had not been provided for the resident since CNA #1 came on duty.</p> <p>Resident #6 was admitted to the facility on February 1, 2007, with diagnoses including Subarachnoid Hemorrhage with Anoxia, History of Left Frontal Craniotomy, Chronic Respiratory Failure, Seizure Disorder, Deep Vein Thrombosis, Frequent Urinary Tract Infection, Tracheostomy, Hydrocephalus with multiple Ventricular Peritoneal Shunt, Hemiplegia, Vegetative State, Barrett Esophagus and History of Gastrointestinal Bleed.</p> <p>Medical record review of the Minimum Data Set (MDS) dated December 10, 2011, revealed the resident was totally dependent on staff for all activities of daily living; was bed confined; had a</p>	F 312	<p><b>What measures will be put in place or what systemic changes you will make to ensure that the deficient practice does not recur.</b></p> <p>The assistant director of nurses will do random audits of residents for the presence of oral and incontinent care being provided daily for 2 weeks, then three times per week for 4, then weekly for 4 weeks.</p> <p>How corrective action will be monitored to ensure the deficient practice will not recur. i.e. what quality assurance program will be put in place.</p> <p>Audit results will be reviewed in the QA Committee meeting with changes to the plan or monitoring as deemed by the QA Committee.</p>	3/22/2012

MAR 23 2012

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/07/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  445242	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  C 03/07/2012
---	---	--	--

NAME OF PROVIDER OR SUPPLIER

GREYSTONE HEALTH CARE CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE

181 DUNLAP ROAD, PO BOX 1133  
BLOUNTVILLE, TN 37617

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 312	<p>Continued From page 6</p> <p>hygiene and bathing; and was occasionally incontinent of bowel and bladder.</p> <p>Medical record review of a bladder evaluation dated December 7, 2011, revealed the resident had one incontinence episode per week with associated symptoms "Fills bladder/voids large amounts."</p> <p>Observation on February 15, 2012, at 1:15 p.m., revealed the resident entered the family room (where the surveyor was working); sat down in a chair for three minutes; got up and ambulated to the adjoining dining room. Observation revealed a strong smell of urine in the family room. Observation revealed the resident was dressed in sweat pants and had been incontinent of a large amount of urine, wetting the pants from the groin to the feet, which was visible from both the front and back of the resident. Observation revealed the resident sat in the adjoining dining room from 1:18 p.m., until 2:36 p.m. Observation revealed a staff member entered the dining room at 1:30 p.m., and left the dining room at 1:40 p.m. Observation revealed two staff members transported two residents to the dining room in wheelchairs, for the resident council meeting, and left the dining room. Observation revealed a staff member entered the dining room at 1:48 p.m. and left the dining room 1:50 p.m. Observation revealed two staff members entered the dining room at 2:00 p.m., for the resident council meeting. Observation revealed the doors to the dining room opened at 2:36 p.m., and resident #7 ambulated from the dining room and sat down on a sofa in the hallway. Observation revealed the resident had been in need of incontinence care one hour and twenty minutes.</p>	F 312		

MAR 23 2012

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/07/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  445242	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  C 03/07/2012
---	---	--	--

NAME OF PROVIDER OR SUPPLIER

GREYSTONE HEALTH CARE CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE

181 DUNLAP ROAD, PO BOX 1133  
BLOUNTVILLE, TN 37617

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 312	Continued From page 7  Observation and interview on February 15, 2012, at 2:37 p.m., in the hallway with the Activities Director confirmed the resident had been incontinent of urine and was in need of incontinence care.  Observation and interview on February 15, 2012, at 2:38 p.m., in the hallway, with the Assistant Director of Nursing confirmed the resident had been incontinent of urine and was in need of incontinence care.,  C/O #28875, #29296	F 312		
F 456 SS=D	483.70(c)(2) ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION  The facility must maintain all essential mechanical, electrical, and patient care equipment in safe operating condition.  This REQUIREMENT is not met as evidenced by: Based on medical record review, observation and interview, the facility failed to ensure one resident's (#4) geri-chair was maintained in a safe condition of seven residents reviewed.  The findings included:  Resident #4 was admitted to the facility on July 22, 2011, with diagnoses including End-Stage Liver Disease secondary to Hepatitis C, Encephalopathy, Chronic Pain, Bipolar Disorder, Osteoarthritis, Anxiety, Depression, Fibromyalgia, Anasarca (severe generalized edema) secondary to Cirrhosis, Anemia, Thrombocytopenia and	F 456	What corrective action(s) will be done for residents found to have been effected by the deficient practice(s).  Resident #4's geri chair was removed from the resident care area on 2/15/2012.  How facility will identify other residents having potential to be affected by practice AND what corrective action will be taken.  Maintenance completed an audit of all the chairs for the need of repair or replacement.  Education was provided to nursing staff and maintenance staff on 2/16/2012 by staff development coordinator regarding notification of chairs that need repair to maintenance and maintenance repairing areas when reported or noted on audits.	3/12/2012

MAR 23 2012

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/07/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>445242</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>03/07/2012</b>
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

**GREYSTONE HEALTH CARE CENTER**

STREET ADDRESS, CITY, STATE, ZIP CODE

**181 DUNLAP ROAD, PO BOX 1133  
BLOUNTVILLE, TN 37617**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 456	<p>Continued From page 8</p> <p>Portal Hypertension.</p> <p>Medical record review of the Minimum Data Set (MDS) dated November 28, 2011, revealed the resident had short and long-term memory problems and severely impaired decision-making skills; required extensive assistance with activities of daily living (ADL); and had bowel and bladder incontinence.</p> <p>Observation with the Licensed Practical Nurse (LPN) #2/Unit Manager on February 16, 2012, at 11:50 a.m., revealed the resident lying in bed. Observation revealed multiple areas on the top and lateral aspect of the right forearm 0.5 cm (centimeters) X (by) 1.0 cm which had the appearance of senile purpura (Hemorrhage into the skin causing discoloration in debilitated or aged persons).</p> <p>Observation and interview with LPN #2/Unit Manager on February 12, 2012, at 12:00 p.m., revealed the geri chair in the resident's room was in need of repair. Observation revealed a section, measuring four inches by one inch, of the plastic which covered the top of the right arm of the geri-chair was missing. Observation revealed an edge of the torn plastic was protruding upward with a rough edge. Observation revealed a hole in the top of the left arm of the chair with hard plastic protruding into the hole. Interview with LPN #2/Unit Manager at the time of the observation confirmed the resident's skin was thin and fragile, and the torn arms of the geri-chair placed the resident at greater risk for skin tears.</p> <p>C/O #28875</p>	F 456	<p><b>What measures will be put in place or what systemic changes you will make to ensure that the deficient practice does not recur.</b></p> <p><b>The facility will complete audit and repair of chairs.</b></p> <p><b>The director of maintenance will do random audits of 15 chairs per week checking for areas that need repair for 4 weeks, then monthly for 4 months.</b></p> <p><b>How corrective action will be monitored to ensure the deficient practice will not recur. i.e. what quality assurance program will be put in place.</b></p> <p><b>Audit results will be reviewed in the QA Committee meeting with changes to the plan or monitoring as deemed by the QA Committee.</b></p>	3/22/2012

MAR 23 2012